Form 151

STATE OF UTAH - LABOR COMMISSION
Industrial Accidents Division
160 East 300 South, P.O. Box 146615
Salt Lake City, UT 84114-6615
(801) 530-6800 1-800-530-5090 TDD (801) 530-7685

DEPENDENT'S BENEFIT INFORMATION

Insurance Carrier Claim Number _____Name of Decedent _____

Date of Industrial Injury or Occupational Disease _____ Date of Death _____

Employer Name _____ Industrial Carrier/TPA (circle one) _____

JOB(s) ON DATE CLAIM AROSE	WAGE PER HOUR	HOURS WORKED PER WEEK
TOTAL WAGES PER WEEK FOR ALL JOBS =		

Dependent Information

NAME	RELATIONSHIP	BIRTH DATE	PRESENT ADDRESS (Including State/City/Zip)

This claim has been (check one): Accepted in full _____ Accepted in part _____ Denied _____

If all or part of the claim has been denied, please attach Form 089 -"Employee Notification of Denial of claim."

ADJUSTER/AUTHORIZED AGENT CONTACT INFORMATION
Name _____ Signature _____
Mailing Address _____
City/State/Zip _____
Telephone Number _____ FAX Number _____